EXECUTIVE SUMMARY
SENIOR LIVING TRUST FUND APPROPRIATION ACT

HOUSE FILE 740

NEW PROGRAMS, SERVICES, OR ACTIVITIES

- Adds a new allocation from the Senior Living Trust Fund to the Department of Elder Affairs for recruitment and retention strategies for certified nurse aides. (Page 1, Line 14)
- Adds a new allocation from the Senior Living Trust Fund to the Department of Elder Affairs for dependent adult abuse detection, training, and services. (Page 1, Line 26)
- Increases the appropriation to the Department of Human Services (DHS) to implement nursing facility provider reimbursement based on a case-mix reimbursement methodology. (Page 1, Line 34)

MAJOR INCREASES, DECREASES, OR TRANSFERS OF EXISTING PROGRAMS

- Increases the appropriation from the Senior Living Trust Fund to the Department of Elder Affairs by $1.1 million and 1.0 FTE position compared to the FY 2001 estimated net appropriation for additional funding for the Senior Living Program, a dependent adult abuse initiative, and recruitment and retention strategies for certified nurse aides. (Page 1, Line 1)
- Increases the appropriation from the Senior Living Trust Fund to the DHS by $6.5 million compared to the FY 2001 estimated net appropriation for nursing facility conversion grants, nursing facility provider reimbursements or reimbursement methodology changes, and to supplement the Medical Assistance appropriation through the Home and Community-Based Waiver and the State Supplementary Assistance Program. (Page 1, Line 34)

STUDIES AND INTENT LANGUAGE

- Requires the Department of Elder Affairs to utilize funds in accordance with the regulations, requirements, or guidelines applicable to the Senior Living Program as set forth by the Health Care Financing Administration (HCFA). (Page 1, Line 29)
- Requires the DHS to adopt rules regarding nursing facility conversion grant applications giving greater priority to nursing facilities that renovate existing structures versus new construction, and to encourage cooperative efforts between the Department of Inspections and Appeals, the State Fire Marshal, and grant applicants in regard to renovation projects. (Page 2, Line 31) *This item was vetoed by the Governor.*
- Requires the Department of Elder Affairs to certify all assisted living programs established through grants, and requires consultation for establishment and monitoring of occupancy agreements. (Page 3, Line 10)
- Specifies that the DHS initiate and implement a system of accountability to measure nursing facility outcomes in the areas of quality of life and efficiency that will be used to increase nursing facility reimbursements based on favorable outcomes. (Page 8, Line 1)
- Specifies that increases in nursing facility reimbursement rates under the case-mix adjusted component be used for the provision of direct care, requires the DHS to compile analyses regarding factors that increase direct care costs, and requires the DHS to submit these analyses to the General Assembly. (Page 8, Line 19)

STUDIES AND INTENT LANGUAGE (CONTINUED)

- Permits the DHS to adopt administrative rules to implement Section 4, Modified Price-Based Case-Mix Reimbursement for Nursing Facilities. (Page 10, Line 35)
- Specifies the award of nursing facility conversion grants on or after July 1, 2001, be used to convert all or a portion of a licensed nursing facility to a certified assisted living program. (Page 11, Line 13)

SIGNIFICANT CHANGES TO THE CODE OF IOWA

- Changes the definition of affordable in terms of rates for payment of services. (Page 11, Line 29) *This item was vetoed by the Governor.*
- Requires the DHS to provide conversion grants from the Senior Living Trust Fund appropriation to a licensed nursing facility that has been an approved provider under the Medical Assistance Program for a two-year period prior to application for the grant. (Page 12, Line 11)
- Requires the DHS to provide conversion grants from the Senior Living Trust Fund appropriation to a long-term care provider or a licensed nursing facility that has been an approved provider under the Medical Assistance Program for a two-year period prior to application for the grant or a provider that will meet applicable medical assistance provider requirements. (Page 12, Line 23)
- Changes the time periods a licensed nursing facility must be an approved provider under the Medical Assistance Program in order to be eligible to receive a conversion grant. (Page 12, Line 11 and Page 12, Line 23)

GOVERNOR'S VETOES

- The Governor vetoed language requiring the DHS to focus nursing facility grant awards on renovation of existing facilities. The Governor indicated the focus should be on providing the appropriate services for persons in need in the most effective manner, whether that be renovation of existing structures or new construction. (Page 2, Line 31)
- The Governor vetoed language requiring an eighty-five (85.0) percent occupancy factor be applied when calculating the non-direct cost component of the modified price-based case-mix reimbursement rate. The Governor indicated that the language would require the State to continue to pay for empty nursing home beds at a time when funding for many services has been cut. (Page 4, Line 29)
- The Governor vetoed language that allows nursing facilities to request an exception to the application of the geographic wage index based upon reasonable demonstration of wages, location, or total cost. The Governor indicated that the language is flawed and that the word "or" should be "and", and the technical correction will be clarified through the rulemaking process. (Page 4, Line 29)

GOVERNOR'S VETOES (CONTINUED)

- The Governor vetoed language which amends Section 249H.3, Subsection 1, Code of Iowa, relating to the definition of "affordable." The Governor indicated that application of this definition expands the scope of the population served by these funds and would use dollars that were intended to benefit Medicaid eligible people to subsidize those not eligible for Medicaid, which does not seem justifiable at a time when resources are limited. (Page 11, Line 29)

ENACTMENT DATE

- This Act was approved by the General Assembly on May 3, 2001, and item vetoed and signed by the Governor on June 1, 2001.

House File 740

House File 740 provides for the following changes to the Code of Iowa.

Page #	Line #	Bill Section	Action	Code Section	Description
2	27	2	Nwthstnds	Sec. 8.33	Nonreversion of Nursing Facility Provider Reimbursement
10	35	4	Nwthstnds	Sec. 17A.4(5) and 17A.8(9)	Administrative Rules
11	29	6	Amends	Sec. 249H.3(1)	Defines Affordability
12	11	7	Amends	Sec. 249H.6(1)(a)	Time Period for Eligibility
12	23	7	Amends	Sec. 249H.6(1)(b)	Time Period for Eligibility

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1 1	Section 1. DEPARTMENT OF ELDER AFFAIRS APPROPRIATION.	Senior Living Trust Fund appropriation to the Department of Elder Affairs for the development of a comprehensive Senior Living Program.
1 2	There is appropriated from the senior living trust fund	
1 3	created in section 249H.4 to the department of elder affairs	
1 4	for the fiscal year beginning July 1, 2001, and ending June	
1 5	30, 2002, the following amount, or so much thereof as is	
1 6	necessary, to be used for the purpose designated:	
1 7	For the development of a comprehensive senior living	
1 8	program, including program administration and costs associated	
1 9	with implementation, salaries, support, maintenance, and	
1 10	miscellaneous purposes, and for not more than the following	
1 11	full–time equivalent positions:	
1 12	..... $ 5,285,426	
1 13	..... FTEs 8.00	
		DETAIL: This is an increase of $1,097,303 and 1.00 FTE position compared to the FY 2001 estimated net appropriation due to: 1. An increase of $741,503 for the creation and expansion of home and community-based services for the elderly through the Senior Living Program. 2. An increase of $255,800 and 1.00 FTE position for dependent adult abuse detection, training, and services. 3. An increase of $100,000 for recruitment and retention strategies for certified nurse aides.
1 14	1. Of the funds appropriated in this section, $100,000	Requires a maximum allocation of $100,000 of the Department of Elder Affairs appropriation be used to fund recruitment and retention strategies, additional training, and support for certified nurse aides in an effort to reduce staff turnover in nursing facilities. Requires the Department of Elder Affairs to contract with an agency or organization whose primary mission is the improvement of the nurse aide profession for this purpose.
1 15	shall be used by the department to fund recruitment and	
1 16	retention strategies to provide additional training and	
1 17	support for certified nurse aides, employed by nursing	
1 18	facilities, as a means of reducing staff turnover. The	
1 19	department shall contract with an agency or organization whose	
1 20	primary purpose is the improvement of the nurse aide	
1 21	profession through the provision of continuing education,	
1 22	support and empowerment programs, and career opportunities	
1 23	within the field of nurse assisting, with the goal of the	
1 24	further stabilization of the nurse aide workforce and the	
1 25	reduction of nurse aide turnover.	
		DETAIL: This is a new allocation for FY 2002.
1 26	2. Of the funds appropriated in this section, $255,800	Requires a maximum allocation of $255,800 of the Department of Elder Affairs appropriation be used for dependent adult abuse detection, training, and services.
1 27	shall be used by the department to fund strategies for	
1 28	dependent adult abuse detection, training, and services.	
		DETAIL: This is a new allocation for FY 2002.

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1 29	3. The funds appropriated under this section shall be used in accordance with any regulations, requirements, or guidelines of the health care financing administration of the United States department of health and human services applicable to the senior living program.	Requires the Department of Elder Affairs to utilize funds appropriated from the Senior Living Trust Fund in accordance with the regulations, requirements, and guidelines applicable to the Senior Living Program as set forth by the Health Care Financing Administration (HCFA).
1 34	Sec. 2. DEPARTMENT OF HUMAN SERVICES APPROPRIATION. There is appropriated from the senior living trust fund created in section 249H.4 to the department of human services for the fiscal year beginning July 1, 2001, and ending June 30, 2002, the following amounts, or so much thereof as is necessary, to be used for the purposes designated:	Senior Living Trust Fund appropriation to the Department of Human Services (DHS) for grants to nursing facilities to convert to assisted living programs or long-term care alternatives and for long-term care alternative grants. DETAIL: Maintains current level of funding.
2 5	1. To provide grants to nursing facilities for conversion to assisted living programs or to provide long–term care alternatives and to provide grants to long–term care providers for development of long–term care alternatives: ..... $ 20,000,000	
2 10	2. To supplement the medical assistance appropriation and to provide reimbursement for health care services and rent expenses to eligible persons through the home and community–based services waiver and the state supplementary assistance program, including program administration and data system costs associated with implementation, salaries, support, maintenance, and miscellaneous purposes, and for not more than the following full–time equivalent positions: ..... $ 1,733,406 ..... FTEs 5.00	Senior Living Trust Fund appropriation to the DHS to supplement the Medical Assistance appropriation for health care services and rent expenses through the Home and Community-Based Waiver and the State Supplementary Assistance Program. DETAIL: This is a decrease of $506,628 and no change in FTE positions compared to the FY 2001 estimated net appropriation.
2 20	3. To implement nursing facility provider reimbursement based upon a case–mix reimbursement methodology: ..... $ 24,750,000	Senior Living Trust Fund appropriation to the DHS to implement nursing facility provider reimbursement increases based on case-mix reimbursement methodology. DETAIL: This is an increase of $7,000,000 compared to the FY 2001 estimated net appropriation.

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2 23	a. In order to carry out the purposes of this subsection,	Requires the DHS to transfer funds to supplement other related appropriations to carry out the purposes of this Subsection.
2 24	the department shall transfer funds appropriated in this	
2 25	section to supplement other appropriations to the department	
2 26	of human services.	
2 27	b. Notwithstanding section 8.33, moneys appropriated under	CODE: Requires that unencumbered or unobligated moneys remain in the Senior Living Trust Fund and not revert to the General Fund at the end of FY 2002.
2 28	this subsection that remain unencumbered or unobligated at the	
2 29	close of the fiscal year shall be retained in the senior	
2 30	living trust fund.	
2 31	Sec. 3. CONVERSION GRANT PROJECTS — RULES — INTENT.	Requires the DHS to adopt rules regarding nursing facility conversion grant applications, giving greater weight to nursing facilities that renovate existing structures. Also, encourages cooperative efforts between the Department of Inspections and Appeals, the State Fire Marshal, and grant applicants in regard to renovation projects. VETOED: The Governor vetoed this Subsection in its entirety, stating the focus should be on providing the appropriate services for persons in need in the most effective manner, whether that be renovation of existing structures or new construction.
2 32	**[**1. The department of human services shall adopt rules that	
2 33	provide that beginning with applications for conversion grants	
2 34	received on or after July 1, 2001, the department shall give	
2 35	greater weight in the scoring methodology to nursing facility	
3 1	conversion projects that are primarily the renovation and	
3 2	remodeling of the existing nursing facility structure and give	
3 3	less weight to conversion projects that are primarily new	
3 4	construction. The department of human services shall	
3 5	encourage cooperative efforts between the department of	
3 6	inspections and appeals, the state fire marshal and the grant	
3 7	applicant to promote the acceptance of nursing facility	
3 8	conversion projects that are primarily renovation and	
3 9	remodeling of the existing nursing facility structure.**]**	
3 10	2. It is the intent of the general assembly that the	Specifies that it is the intent of the General Assembly that the Department of Elder Affairs certify all assisted living programs established through grants, and requires consultation for establishment and monitoring of occupancy agreements.
3 11	department of elder affairs certify all assisted living	
3 12	programs established through nursing facility conversion	
3 13	grants. The department of elder affairs shall consult with	
3 14	conversion grant applicants and recipients to establish and	
3 15	monitor occupancy agreements and assisted living program	
3 16	residents shall be allowed access to third–party payors. The	
3 17	department of elder affairs shall allow grant recipients to	
3 18	revise and modify occupancy agreements to reflect rates that	
3 19	are affordable, as defined in section 249H.3, during the ten–	
3 20	year period of operation following the awarding of the grant	
3 21	by the department of human services.	

VETOED

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3 22	Sec. 4. MODIFIED PRICE–BASED CASE–MIX REIMBURSEMENT — NURSING FACILITIES.	Requires the DHS to reimburse nursing facilities in accordance with a phased-in, modified price-based case-mix reimbursement system.
3 24	1. Beginning July 1, 2001, the department of human services shall reimburse nursing facilities under the medical assistance program in accordance with a phased–in, modified price–based case–mix reimbursement system that includes a case–mix adjusted component and a non–case–mix adjusted component.	
3 30	2. The modified price–based case–mix reimbursement rate shall be phased in over a three–year period.	Requires the DHS to phase in the modified price-based case-mix reimbursement rate over a three-year period.
3 32	a. For the fiscal year beginning July 1, 2001, and ending June 30, 2002, 66.67 percent of a facility's reimbursement rate shall be computed based on the current rate and 33.33 percent shall be computed based on the modified price–based case–mix reimbursement rate. The current rate portion shall be calculated from the cost reports submitted by nursing facilities for the period ending on or before December 31, 2000, plus an inflation factor of 6.21 percent, with a maximum current rate portion of $94.00. A nursing facility shall not receive a reimbursement rate under this paragraph that is less than the rate received on June 30, 2001, plus an inflation factor of 6.21 percent. For the purposes of this calculation, any excess payment allowance received by the facility shall not be considered part of the reimbursement rate.	Requires the DHS to compute a facility's reimbursement rate for FY 2002 by computing 66.67% of the reimbursement based on the cost-based rate and 33.33% based on the price-based, case-mix rate. Requires the cost-based rate be calculated from cost reports submitted by nursing facilities on or before December 31, 2000, to include an inflation factor of 6.21%, with the maximum reimbursement rate of $94.00 per day. Specifies that the reimbursement rate is to be no less than the rate received on June 30, 2001, plus the inflation factor.
4 11	b. For the fiscal year beginning July 1, 2002, and ending June 30, 2003, 33.33 percent of a facility's reimbursement rate shall be computed based on the current rate and 66.67 percent shall be computed based on the modified price–based case–mix reimbursement rate. The current rate portion shall be calculated from the current rate for the previous state fiscal year, plus an additional inflation factor based on HCFA/SNF index, with an estimated maximum current rate portion of $97.47. A nursing facility shall not receive a	Requires the DHS to compute a facility's reimbursement rate for FY 2003 by computing 33.33% of the reimbursement based on the cost-based rate and 66.67% based on the price-based, case-mix rate. Requires the cost-based rate be calculated from the cost-based rate for FY 2002, to include an inflation factor based on the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) index,

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4 20	reimbursement rate under this paragraph that is less than the rate received on June 30, 2002, plus an inflation factor based on the HCFA/SNF index. For the purposes of this calculation, any excess payment allowance received by the facility shall not be considered part of the reimbursement rate.	with an estimated maximum reimbursement rate of $97.47. Specifies that the reimbursement rate is to be no less than the rate received on June 30, 2002, plus the inflation factor.
4 25	c. For the fiscal year beginning July 1, 2003, and ending June 30, 2004, and thereafter, 100 percent of a facility's reimbursement rate shall be computed based on the modified price–based case–mix reimbursement rate.	Requires the DHS to compute 100.00% of nursing facility reimbursement based on the price-based, case-mix reimbursement rate for FY 2004.
4 29	3. Modified price–based case–mix reimbursement rate calculation.	Specifies how the DHS shall calculate the modified price-based case-mix reimbursement rate for FY 2002 - FY 2004 and each year thereafter. Includes requiring an 85.00% occupancy factor be applied when calculating the non-direct cost component of the reimbursement rate.
4 31	a. The department of human services shall determine the statewide median of nursing facility costs as follows:	
4 33	(1) For the fiscal period beginning July 1, 2001, and ending June 30, 2003, the department shall determine the statewide median of nursing facility costs based upon each facility's actual costs taken from the most recent cost reports, submitted by the nursing facility for the period ending on or before December 31, 2000, subject to certain existing limitations and adjustments. These costs shall be inflated forward to July 1, 2001, by using the midpoint of each cost report and applying the HCFA/SNF index.	
5 7	(2) Beginning July 1, 2003, and every other fiscal year thereafter beginning on July 1 of the respective state fiscal year, the department shall recalculate the statewide median of nursing facility costs based upon the most recent cost reports submitted by the nursing facility for the period ending on or before December 31 of the previous calendar year and shall inflate these costs forward to the beginning of the state fiscal year by using the midpoint of each cost report and applying the HCFA/SNF index.	
5 16	**[**b. Beginning July 1, 2003, and thereafter, an occupancy factor of 85 percent shall be applied when calculating the nondirect care cost component of the modified price–based case–mix reimbursement rate. The occupancy factor shall not	**VETOED** VETOED: The Governor vetoed Subsection 3(b) in its entirety, indicating that the language would require the State to continue to pay for empty nursing home beds at a time when funding for many services has been cut. The Governor also vetoed the last three sentences of Subsection 3(g), indicating that the language is flawed, that the word "or" should be "and" relating to total cost, and the technical correction will be clarified through the rulemaking process.

apply to support care costs.**]**

c. The modified price–based case–mix reimbursement rate paid to nursing facilities shall be calculated using the statewide median cost as adjusted to reflect the case mix of the medical assistance residents in the nursing facility.

d. (1) The department of human services shall use the resource utilization groups–III (RUG–III), version 5.12b, 34 group, index maximizer model as the resident classification system to determine a nursing facility's case–mix index, based on data from the minimum data set (MDS) submitted by each facility. Standard version 5.12b, 34 group case–mix indices, developed by HCFA, shall be the basis for calculating the average case–mix index and shall be used to adjust the direct–care component in the determination of the rate ceiling and the modified price–based case–mix reimbursement rate.

(2) The department of human services shall determine and adjust each facility's case–mix index on a quarterly basis. A separate calculation shall be made to determine the average case–mix index for a facilitywide case–mix index, and a case–mix index for the medical assistance residents of the nursing facility using the minimum data set (MDS) report submitted by the facility for the previous quarter, which reflects the residents in the facility on the last day of the previous calendar quarter.

e. The department shall calculate the rate ceiling for the direct–care cost component at 120 percent of the median of case–mix adjusted costs. Nursing facilities with case–mix adjusted costs at 95 percent of the median or greater, shall receive an amount equal to their costs not to exceed 120 percent of the median. Nursing facilities with case–mix adjusted costs below 95 percent of the median shall receive an excess payment allowance by having their payment rate for the direct–care cost component calculated as their case–mix adjusted cost plus 100 percent of the difference between 95 percent of the median and their case–mix adjusted cost, not to exceed 10 percent of the median of case–mix adjusted costs. Any excess payment allowance realized from the direct care

cost component of the modified price–based case–mix reimbursement shall be expended to increase the compensation of direct care workers or to increase the ratio of direct care workers to residents. The department of human services shall implement a new monitoring and reporting system to assess compliance with the provisions of this paragraph.

f. The department shall calculate the rate ceiling for the nondirect care cost component at 110 percent of the median of non–case–mix adjusted costs. Nursing facilities with non–case–mix adjusted costs at 96 percent of the median or greater shall receive an amount equal to their costs not to exceed 110 percent of the median. Nursing facilities with non–case–mix adjusted costs below 96 percent of the median shall receive an excess payment allowance that is their costs plus 65 percent of the difference between 96 percent of the median and their non–case–mix adjusted costs, not to exceed 8 percent of the median of non–case–mix adjusted costs. Any excess payment allowance realized from the nondirect care cost component of the modified price–based case–mix reimbursement shall be used to fund quality of life improvements. The department of human services shall implement a new monitoring and reporting system to assess compliance with the provisions of this paragraph.

g. The department shall apply the geographic wage index adjustment annually to the case–mix adjusted component of the modified price–based case–mix reimbursement rate for nursing facilities located in standard metropolitan statistical area counties in Iowa identified by HCFA. This rate shall be calculated using the case–mix adjusted costs of the nursing facility, not to exceed $8 per patient day. **[**A nursing facility may request an exception to application of the geographic wage index based upon a reasonable demonstration of wages, location, or total cost. A request for an exception shall be submitted to the department of human services within 30 days of receipt of notification by the nursing facility of the new reimbursement rate. The exception request shall include an explanation of the circumstances and supporting data.**]**

VETOED

h. For the purpose of determining the median applicable to Medicare–certified hospital–based skilled nursing facilities, the department shall treat such facilities as a separate peer group.

i. The modified price–based case–mix reimbursement rate for state–operated nursing facilities and special population nursing facilities shall be the average allowable per diem costs, adjusted for inflation, based on the most current financial and statistical report. Special population nursing facilities enrolled on or after June 1, 1993, shall have a rate ceiling equal to the rate ceiling for Medicare–certified hospital–based nursing facilities.

4. ACCOUNTABILITY MEASURES.

a. It is the intent of the general assembly that the department of human services initiate a system to measure a variety of elements to determine a nursing facility's capacity to provide quality of life and appropriate access to medical assistance program beneficiaries in a cost–effective manner. Beginning July 1, 2001, the department shall implement a process to collect data for these measurements and shall develop procedures to increase nursing facility reimbursements based upon a nursing facility's achievement of multiple favorable outcomes as determined by these measurements. Any increased reimbursement shall not exceed 3 percent of the calculation of the modified price–based case–mix reimbursement median. The increased reimbursement shall be included in the calculation of nursing facility modified price–based payment rates beginning July 1, 2002, with the exception of Medicare–certified hospital–based nursing facilities, state–operated nursing facilities, and special population nursing facilities.

Specifies it is the intent of the General Assembly that the DHS initiate a system of accountability measures regarding a nursing facility's capacity to provide quality of life and access to medical assistance program beneficiaries. Requires the DHS to implement a process to collect data regarding accountability measures and to develop procedures to increase nursing facility reimbursement not more than 3.00% as a result of favorable outcomes based on these measurements.

b. It is the intent of the general assembly that increases in payments to nursing facilities under the case–mix adjusted component shall be used for the provision of direct care with an emphasis on compensation to direct care workers. The department shall compile and provide a detailed analysis to

Specifies it is the intent of the General Assembly that increases in nursing facility reimbursement rates under the case-mix adjusted component be used for the provision of direct care. Requires the DHS

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8 24 demonstrate growth of direct care costs, increased acuity, and 8 25 care needs of residents. The department shall also provide 8 26 analysis of cost reports submitted by providers and the 8 27 resulting desk review and field audit adjustments to 8 28 reclassify and amend provider cost and statistical data. The 8 29 results of these analyses shall be submitted to the general 8 30 assembly for evaluation to determine payment levels following 8 31 the transition funding period.		to compile information regarding the growth of direct care costs, increased acuity, resident care needs, and provider cost reports. Requires the DHS to provide the results of these analyses to the General Assembly.
8 32 5. As used in this section: 8 33 a. "Case–mix" means a measure of the intensity of care and 8 34 services used by similar residents in a facility. 8 35 b. "Case–mix adjusted costs" means specified costs 9 1 adjusted for acuity by the case–mix index. Costs subject to 9 2 adjustment are the salaries and benefits of registered nurses, 9 3 licensed practical nurses, certified nursing assistants, 9 4 rehabilitation nurses, and contracted nursing services. 9 5 c. "Case–mix index" means a numeric score within a 9 6 specific range that identifies the relative resources used by 9 7 similar residents and represents the average resource 9 8 consumption across a population or sample. 9 9 d. "Excess payment allowance" means an amount stated as a 9 10 percentage that is calculated as a percent of the difference 9 11 between the excess payment ceiling and a nursing facility's 9 12 costs. 9 13 e. "Excess payment ceiling" or "profit ceiling" means an 9 14 amount stated in terms of per patient day that is calculated 9 15 as a percent of the median. 9 16 f. "Facilitywide average case–mix index" is a simple 9 17 average, carried to four decimal places, of all resident case– 9 18 mix indices based on the last day of each calendar quarter. 9 19 g. "Geographic wage index" means an annual calculation of 9 20 the average difference between the hospital–based rural wage 9 21 index for Iowa and Iowa hospital–based standard metropolitan 9 22 statistical area wage indices as published by HCFA each July. 9 23 The wage factor shall be revised when the skilled nursing 9 24 facility wage indices are released by HCFA.		Provides definitions for the following terms contained in the Bill: 1. Case-mix 2. Case-mix adjusted costs 3. Case-mix index 4. Excess payment allowance 5. Excess payment ceiling or profit ceiling 6. Facilitywide average case-mix index 7. Geographic wage index 8. Health Care Financing Administration (HCFA) 9. Health Care Financing Administration/Skilled Nursing Facilities (HCFA/SNF) Index 10. Median 11. Medicaid or Medical Assistance 12. Medicaid average case-mix index 13. Medicare 14. Minimum Data Set (MDS) 15. Non-case mix adjusted costs 16. Nursing facility 17. Rate ceiling or upper payment limit 18. Special population nursing facility

h. "HCFA" means the health care financing administration of the United States department of health and human services.

i. "HCFA/SNF index" means the HCFA total skilled nursing facility market basket index published by data resources, inc. The HCFA/SNF index listed in the latest available quarterly publication prior to the July 1 rate setting shall be used to determine the inflation factor which shall be applied based upon the midpoint of the cost report period.

j. "Median" means the median cost calculated by using a weighting method based upon total patient days of each nursing facility.

k. "Medicaid" or "medical assistance" means medical assistance as defined in section 249A.2.

l. "Medicaid average case–mix index" means the simple average, carried to four decimal places, of all resident case–mix indices where Medicaid is known to be the per diem payor source on the last day of the calendar quarter.

m. "Medicare" means the federal Medicare program established by Title XVIII of the federal Social Security Act.

n. "Minimum data set" or "MDS" means the federally required resident assessment tool. Information from the MDS is used by the department to determine the facility's case–mix index.

o. "Non–case–mix adjusted costs" means an amount stated in terms of per patient day that is calculated using allowable costs from the cost reports of facilities, divided by the allowable patient days for the cost report period, and beginning July 1, 2003, patient days as modified pursuant to subsection 3, paragraph "b". Non–case–mix adjusted costs include all allowable costs less case–mix adjusted costs.

p. "Nursing facility" means a skilled nursing facility certified under both the federal Medicaid program and the federal Medicare program, and a nursing facility certified under the federal Medicaid program.

q. "Rate ceiling" or "upper payment limit" means a maximum rate amount stated in terms of per patient day that is calculated as a percent of the median.

r. "Special population nursing facility" means a skilled nursing facility the resident population of which is either of the following:

(1) One hundred percent of the residents of the nursing facility is under the age of 22 and require the skilled level of care.

(2) Seventy percent of the residents served requires the skilled level of care for neurological disorders.

6. The department of human services may adopt rules under section 17A.4, subsection 2, and section 17A.5, subsection 2, paragraph "b", to implement this section. The rules shall become effective immediately upon filing, unless the effective date is delayed by the administrative rules review committee, notwithstanding section 17A.4, subsection 5, and section 17A.8, subsection 9, or a later effective date is specified in the rules. Any rules adopted in accordance with this section shall not take effect before the rules are reviewed by the administrative rules review committee. Any rules adopted in accordance with the provisions of this section shall also be published as notice of intended action as provided in section 17A.4.

Permits the DHS to adopt administrative rules to implement Section 4, Modified Price-Based Case-Mix Reimbursement for Nursing Facilities. The rules are effective upon filing or on a later date specified in the rules. Publication of intended action is required.

CODE: Requires that the administrative rules become effective immediately upon filing unless the Administrative Rules Committee delays the effective date, or a later date is specified in the rules.

Sec. 5. NURSING FACILITY CONVERSION GRANTS. The nursing facility conversion grants awarded on or after July 1, 2001, may be used to convert all or a portion of the licensed nursing facility to a certified assisted–living program. The conversion program shall provide a service delivery package that is affordable for those individuals eligible for services under the medical assistance home and community–based services waiver program applicable to a minimum of 40 percent of the units. The reimbursement rates for the costs paid under the medical assistance program apply only to those clients participating in the medical assistance program. The department of human services shall adjust the criteria for eligibility for conversion grants to allow a licensed nursing facility that has been an approved provider under the medical

Permits the award of nursing facility conversion grants on or after July 1, 2001, be used to convert all or a portion of a licensed nursing facility to a certified assisted living program. Provides conversion program criteria for service affordability, reimbursement rate costs, and eligibility. Requires the DHS to adjust criteria for eligibility for conversion grants.

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11 27 assistance program for a two–year period to apply for a
11 28 conversion grant beginning July 1, 2001.

11 29 **[**Sec. 6. Section 249H.3, subsection 1, Code 2001, is
11 30 amended to read as follows:
11 31 1. "Affordable" means rates for payment of room, board,
11 32 amenities, and medical and health services which ~~do not exceed~~
11 33 ~~the rates established for providers of medical and health~~
11 34 ~~services under the medical assistance program with eligibility~~
11 35 ~~for an individual equal to the eligibility for medical~~
12 1 ~~assistance pursuant to section 249A.3~~ may be purchased, in
12 2 conjunction with third–party payors, by seniors with low and
12 3 moderate incomes in the market area of the providers of such
12 4 services. ~~In relation to services provided by a provider of~~
12 5 ~~services under a home and community–based waiver, "affordable"~~
12 6 ~~means that the total monthly cost of the home and community–~~
12 7 ~~based waiver services provided does not exceed the cost for~~
12 8 ~~that level of care as established by rule by the department of~~
12 9 ~~human services, pursuant to chapter 17A, in consultation with~~
12 10 ~~the department of elder affairs.~~**]**

VETOED

CODE: Amends the definition of affordable in terms of rates for payment of services.

VETOED: The Governor vetoed this Section in its entirety, indicating that application of this definition expands the scope of the population served by these funds and would use dollars that were intended to benefit Medicaid eligible people to subsidize those not eligible for Medicaid, which does not seem justifiable at a time when resources are limited.

12 11 Sec. 7. Section 249H.6, subsection 1, paragraphs a and b,
12 12 Code 2001, are amended to read as follows:
12 13 a. A licensed nursing facility that has been an approved
12 14 provider under the medical assistance program for the ~~three–~~
12 15 ~~year~~ two–year period prior to application for the grant. The
12 16 grant awarded may be used to convert all or a portion of the
12 17 licensed nursing facility to a certified assisted–living
12 18 program and may be used for capital or one–time expenditures,
12 19 including but not limited to start–up expenses, training
12 20 expenses, and operating losses for the first year of operation
12 21 following conversion associated with the nursing facility
12 22 conversion.

CODE: Specifies a change in the number of years, from three years to two years, that a facility must have been an approved provider under the Medical Assistance Program in order to apply for a conversion grant.

PG LN	House File 740	Explanation
12 23	b. A long–term care provider or a licensed nursing	CODE: Specifies a change in the number of years, from three years to two years, that a long-term care provider or licensed nursing facility must have been an approved provider under the Medical Assistance Program in order to apply for a conversion grant.
12 24	facility that has been an approved provider under the medical	
12 25	assistance program for the ~~three–year~~ two–year period prior to	
12 26	application for the grant or a provider that will meet	
12 27	applicable medical assistance provider requirements as	
12 28	specified in subsection 2, paragraph "c" or "d". The grant	
12 29	awarded may be used for capital or one–time expenditures,	
12 30	including but not limited to start–up expenses, training	
12 31	expenses, and operating losses for the first year of operation	
12 32	for long–term care service development.	
12 33	HF 740	
12 34	pf/es/25	